# FY 23-24

# QUALITY ASSURANCE & PERFORMANCE IMPROVEMENT WORK PLAN


Behavioral Health Services (BHS)
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July 1, 2023 – June 30, 2024

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# MADERA COUNTY BEHAVIORAL HEALTH SERVICES

## QUALITY IMPROVEMENT WORK PLAN OVERVIEW

The programs covered in this Quality Assurance & Performance Improvement Work Plan (QAPI) are provided through Madera County Behavioral Health Services in accordance with our Mission Statement, Vision Statement, and our Core Values.

## MISSION STATEMENT

To promote the prevention of and recovery from mental illness and substance abuse for the individuals, families, and communities we serve by providing accessible, caring, and culturally competent services.

## VISION STATEMENT

We envision a world where all persons with addictions and mental illness can achieve recovery and can live with dignity and respect as valued members of their families and communities.

## CORE VALUES

We, the employees of Madera County Behavioral Health Services, value the:

- Promotion of mental health and recovery from mental illness disability.
- Integrity of individual and organizational actions.
- Dignity, worth, and diversity of all people.
- Importance of human relationships.
- Contribution of each employee, clients and families.

## QUALITY MANAGEMENT PROGRAM STATE MANDATE

According to the State Department of Health Care Services, the Quality Management (QM) Program clearly defines the QM Program's structure and elements, assigns responsibility to appropriate individuals, and adopts or establishes quantitative measures to assess performance and to identify and prioritize area(s) for improvement. The QM Program shall be evaluated annually and updated as necessary per Title 9, CCR, Section 1810.440(a)(6) and Title 42, CFR, Section 438.240(e).

**Quality Management (QM) Program**

The QM Program shall;

- Conduct performance monitoring activities throughout its operations.
- Activities shall include but not be limited to;
    - Client and system outcomes,
    - Utilization management,
    - Utilization review,
    - Provider appeals,
    - Credentialing and monitoring, and
    - Resolution of beneficiary grievances.
- Ensure continuity and coordination of care with physical health care providers.
- Coordinate with other human services agencies used by its beneficiaries.
- Assess the effectiveness of any MOU with a physical health care plan.
- Have mechanisms to detect both underutilization of services and overutilization of services, as required by Title 42, CCR, Section 438.240(b)(3).
- Implement mechanisms to assess beneficiary/family satisfaction. The Contractor shall assess beneficiary/family satisfaction by:
    - Surveying beneficiary/family satisfaction with the Contractor's services at least annually;
    - Evaluating beneficiary grievances, appeals, and fair hearings at least annually; and
    - Evaluating requests to change persons providing services at least annually.
    - Inform providers of the results of beneficiary/family satisfaction activities.
- Implement mechanisms to monitor the safety and effectiveness of medication practices.
    - The monitoring mechanism shall be under the supervision of a person licensed to prescribe or dispense prescription drugs.
    - Monitoring shall occur at least annually.
- Implement mechanisms to address meaningful clinical issues affecting beneficiaries' system-wide.
    - Monitor appropriate and timely intervention of occurrences that raise the quality-of-care concerns.
    - Take appropriate follow-up action when such an occurrence is identified.
    - Results of the intervention shall be evaluated by the Contractor at least annually.

**Quality Management Work Plan (QMWP)**

MCBHS shall have a QM Work Plan covering the current contract cycle with documented annual evaluations and documented revisions as needed. The QM Work Plan shall include:

- Evidence of the monitoring activities including, but not limited to,
    - Review of beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5) and Title 42, CFR, section 438.416;
    - Evidence that QM activities, including performance improvement projects, have contributed to meaningful improvement in clinical care and beneficiary service;

- A description of completed and in-process QM activities, including performance improvement projects. The description shall include:
    - Monitoring efforts for previously identified issues, including tracking issues over time;
    - Objectives, scope, and planned QM activities for each year; and,
    - Targeted areas of improvement or change in service delivery or program design.
- A description of mechanisms Contractor has implemented to assess the accessibility of services within its service delivery area. This shall include;
    - Goals for responsiveness for the Contractor's 24-hour toll-free telephone number,
    - Timeliness for scheduling of routine appointments,
    - Timeliness of services for urgent conditions, and
    - Access to after-hours care.
- Evidence of compliance with the requirements for cultural competence and linguistic competence specified in Title 9, CCR, Section 1810.410.

**Quality Improvement (QI) Program**

The QI Program shall be accountable to the Behavioral Health Director as described in Title 9 CCR, Section 1810.440(a) (1). Operation of the QI program shall include substantial involvement by a licensed mental health staff person, as described in Title 9 CCR, Section 1810.440(a)(4). The QI Program shall include active participation by practitioners and providers, as well as consumers and family members in the planning, design, and execution of the QI Program, as described in Title 9 CCR, Section 1810.440(a)(2)(A-C).

There shall be a minimum of two active Performance Improvement Projects (PIPs) that meet the criteria in Title 42, CFR, Section 438.240(b)(1) and (d). Each performance improvement projects shall focus on a clinical area, as well as one non-clinical area.

**QI Activities**

QI activities shall include:

- Collecting and analyzing data to measure against the goals stated in the QI/QM annual work plan, which prioritized areas of improvement that have been identified;
- Identifying opportunities for improvement and deciding which opportunities to pursue;
- Identifying relevant committees internal or external to ensure appropriate exchange of information with the QI Committee;
- Obtaining input from providers, consumers, and family members in identifying barriers to delivery of clinical care and administrative services;
- Designing and implementing interventions for improving performance;
- Measuring effectiveness of the interventions;
- Incorporating successful interventions into the BHS Department operations as appropriate;
- Reviewing beneficiary grievances, appeals, expedited appeals, fair hearings, expedited fair hearings, provider appeals, and clinical records review as required by Title 9, CCR, Section 1810.440(a)(5).

### QI Program Committee (MCBHS Quality Management Committee)

The QI program shall monitor the service delivery system with the aim of improving the processes of providing care and better meeting the needs of its clients. The QI Program Committee shall;

- Review the quality of specialty mental health services provided to beneficiaries.
- Recommend policy decisions;
- Review and evaluate the results of QI activities, including;
    - Performance improvement projects;
    - Institute needed QI actions;
    - Ensure follow-up of QI processes; and
    - Document QI Committee meeting minutes regarding decisions and actions that were taken.

### Quality Assurance (QA)

MCBHS shall set standards and implement processes that will support understanding of, and compliance with, documentation standards set forth in the State Department of Health Care Services contract and any standards set by MCBHS. QA activities may include monitoring performance so that the documentation of care provided will satisfy the requirements set forth in the State Department of Health Care Service's contract. The documentation standards for client care are minimum standards to support claims for the delivery of specialty mental health services. All standards shall be addressed in the client record.

### Utilization Management (UM) Program

The Utilization Management Program shall;

- Be responsible for assuring that beneficiaries have appropriate access to specialty mental health services as required in Title 9, CCR, Section 1810.440(b)(1-3).
- Evaluate medical necessity, appropriateness, and efficiency of services provided to Medi-Cal beneficiaries prospectively or retrospectively.
- Implement mechanisms to assess the capacity of service delivery for its beneficiaries. This includes monitoring the number, type, and geographic distribution of mental health services within the Department's delivery system.
- Implement mechanisms to assess the accessibility of services within its service delivery area. This shall include the assessment of responsiveness of the Contractor's 24-hour toll-free telephone number, timeliness of scheduling routine appointments, timeliness of services for urgent conditions, and access to after-hours care.
- Implement mechanisms to assure authorization decision standards are met. Authorization of services shall include all the following:
    - Pursuant to Title 42, CFR, Section 438.210(b)(1), the Contractor and its subcontractors must have in place, and follow, written policies and procedures for processing requests for initial and continuing authorizations of services.
    - Pursuant to Title 42, CFR, Section 438.210(b)(2), the Contractor shall have in effect mechanisms to ensure consistent application of review criteria for authorization decisions and shall consult with the requesting provider when appropriate.
    - Pursuant to Title 42, CFR, Section 438.210(b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested shall be made by a health care professional who has appropriate clinical expertise in treating the beneficiary's condition or disease.

- Decisions must be made within the timeframes outlined for service authorizations in Title 42, CFR Section 438.210(d), and notices of action related to such decisions must be provided within the timeframes set forth in Title 42, CFR, Section 438.404.(c).

**Departmental Quality Committees**

The ***Quality Improvement Committee (QIC)*** provides ongoing operational leadership of continuous quality improvement activities in the department. It meets quarterly and consists of the following individuals:

| Name | Title/Department |
|---|---|
| | |
| Connie Moreno-Peraza, LCSW | Director, Behavioral Health Services |
| Etisha Wilbon, LMFT | Assistant Director, Behavioral Health Services |
| Herbert Cruz, M.D. | Medical Director, Behavioral Health Services |
| Andrea Martinez, BBHS | Deputy Director of Operations, Behavioral Health Services |
| Art Galindo, LCSW | Children's System of Care Division Manager, Behavioral Health Services |
| Joaquin "Jake" Gonzalez, AMFT | Adult/FSP/Crisis System of Care Division Manager, Behavioral Health Services |
| Eva H. Weikel, MBA | Quality, Compliance, and Admin. Srvcs. Division Manager, Behavioral Health Services |
| Miravel Navarro, MA | Substance Use Disorder Division Manager, Behavioral Health Services |
| Kimberlee Hernandez | Administrative Analyst, Behavioral Health Services |
| Say Yang | Administrative Analyst, Behavioral Health Services |
| Lisa Bernal | Administrative Analyst, Behavioral Health Services |
| Michael McKinney | Peer Support, Behavioral Health Services |
| Claudia Camarena | Administrative Assistant, Behavioral Health Services |
| Shawn Jenkins | Chief Operating Officer, Westcare |
| Mary Ann Knoy | Director of Special Projects, Westcare |
| Michelle Allen | Director of Contract Compliance, Westcare |

| | |
|---|---|
| Terry Walker | Quality Assurance Assistant, Westcare |
| Edward Crossman, LMFT | Clinical Director, Westcare |
| Jana Todd, LCSW | Owner, JDT Consultants, Inc. |
| Andrea Evans | CEO, Valley Teen Ranch |
| Kim Gerhardt | Counselor, Valley Teen Ranch |
| Arlene Vargas | Director of Residential Programs, Promesa Behavioral Health |

## Other Department QI Activities/Committees

The Department has other standing committees where QI/UM activities occur. These include the Performance Improvement Project (PIP) committees, Medication Monitoring Committee, Quality Improvement Committee (QIC), etc. Other committees are created as necessary to examine and resolve quality improvement issues.

## Department Communication of QI Activities

The Department supports QI activities through the planned coordination and communication of the results of measurement of QI initiatives. There are overall efforts to continually improve the quality of care provided. Through planned and shared communication, the Mental Health Board, staff, clients and family members, stakeholders, etc., have knowledge of ongoing QI initiatives as a means of continually improving overall program performance.

*This planned communication may take place through the following methods;*

- *Posters and brochures displayed in common areas*
- *Recipients participating in QI Committee reporting back to recipient groups*
- *Sharing of the Department's annual QI Plan evaluation*
- *Emails*
- *The agency's newsletter*
- *Department Initiatives posted on Public Share (Intranet – PS) and the MCBHS website and Facebook*
- *Presentations to the Mental Health Board*

## GOALS AND OBJECTIVES

The Quality Improvement Committee and other committees that deal with quality issues such as the QIC committee, program planning committees, etc., identify and define goals and specific objectives to be accomplished each year. Progress in meeting these goals and objectives is an important part of the annual evaluation of quality improvement activities.

The following are the ongoing long-term goals for the Department's QI Program and the specific objectives for accomplishing these goals for FY 2020-21.

- To implement quantitative measurement to assess key processes or outcomes;
- To bring managers, clinicians, and staff together to review quantitative data and major clinical adverse occurrences and to identify problems;
- To carefully prioritize identified problems and set goals for their resolution;
- To achieve measurable improvement in the highest priority areas;
- To meet internal and external reporting requirements;
- To provide education and training to managers, clinicians, and staff.
- To develop or adopt necessary tools, such as practice guidelines, assessment tools, consumer and staff surveys, and quality indicators.

### Performance Measurement

Performance Measurement is the process of regularly assessing the results produced by a program/service. It involves:

- Identifying processes, systems, and outcomes that are integral to the performance of service delivery,
- Selecting indicators of these processes or outcomes,
- Analyzing information related to these indicators on a regular basis,
- Acting as needed based on data analysis and the opportunities to improve performance as identified.

The ***purpose*** of measurement and assessment is to:

- Assess the stability of processes or outcomes to determine whether there is an undesirable degree of variation or a failure to perform at an expected level.
- Identify problems and opportunities to improve the performance of processes.
- Assess the outcome of the care provided.
- Assess whether a new or improved process meets performance expectations.

This involves the:

- Selection of a process or outcome to be measured
- Identification and/or development of performance indicators for the selected process or outcome to be measured.
- Aggregating data so that it is summarized and quantified to measure a process or outcome.
- Assessment of performance regarding these indicators at planned and regular intervals.
- Taking action to address performance discrepancies when indicators indicate that a process is not stable, not performing at an expected level or represents an opportunity for quality improvement.
- Reporting on findings, conclusions, and actions taken because of performance assessment.

**Selection of a Performance Indicator**

A performance indicator is a quantifiable behavior change that, when measured, provides information about the performance of a program/services process, functions, or outcomes. Selection of a Performance Indicator for each of the services within MCBHS is based on the following considerations:

- Relevance to the Department's mission.
- Clinical importance - whether it addresses a clinically important process that is:
    - high volume
    - problem prone
    - high risk
    - client satisfaction with services
    - Cultural competency of services, etc.

**The Performance Indicators Selected for the Department Program's Quality Improvement Plan.**

For purposes of this plan, an indicator(s) comprises the following *key elements*: name, goals, objectives, activities, responsible person, and data to be collected, the frequency of analysis or assessment, and preliminary ideas for improvement.

Evaluation is accomplished by comparing actual performance on an indicator with:

- *Describing the progress in achieving the Target*
    - *Activity toward achieving the target, number of people served,*
    - *What was done? Who participated? How many clients were involved?*
    - *What indicators (concrete, observable things) were looked at to see whether progress was being made toward the goal?*
    - *What was used to measure the desired result?*

    - *Describe how the desired result was measured and what indicators were used to measure*
- *Describing relevant evaluation data (results compared with standards, including statistics and qualitative information)*
    - *Any stories used to illustrate the statistics or qualitative information?*
- *Comparing results of the evaluation with the target. Results compared with standards?*
- *Exploring ideas for improvement or any next steps*

Once the performance of a selected process has been measured, assessed, and analyzed, the information gathered by the above performance indicator(s) is used to identify a continuous quality improvement initiative to be undertaken. The decision to undertake the initiative is based upon program/service priorities. The purpose of an initiative is to improve the performance of existing services or to design new ones.

The model in use at MCBHS is the Logic Model. This model was mandated by the State Department of Health Care Services (DHCS) and the Mental Health Services Oversight and Accountability Commission (MHSOAC) for the development, measurement, and monitoring of the MHSA programs. The Logic Model in use by MCBHS was developed by the United Way. It consists of the following;

- What is the mission or overall singular purpose or desired result?
- What are the inputs?
    - Resources dedicated to or consumed by the program, e.g., money, staff, time volunteers, equipment, supplies, etc.
    - What are the constraints on the program, e.g., laws regulations, funding requirements, etc.
    - SWOT—strengths and weaknesses, opportunities, and threats
- Establish goals—SMARTER
    - Specific
    - Measurable
    - Acceptable
    - Realistic
    - Time frame
    - Extending—stretch the performer's capabilities
    - Rewards/recognition when goal/outcome is achieved
- Build in accountability (regularly review who's doing what and by when)
- Note deviations from the plan and re-plan accordingly
- Evaluate the planning process and plan

This method was used with clients/family members and other stakeholders in the development of the Department's MHSA Prevention, Early Intervention Programs, and the MHSA Innovation plan. Clients/family members and stakeholders were used for the setting of goals/objectives for the program.

**Evaluation**

An evaluation is completed at the end of each fiscal year. The annual evaluation is conducted by the MHP and kept on file, along with the Quality Improvement Plan. These documents will be reviewed by the Quality Management Committee and others as appropriate.

The evaluation summarizes the following;

- The goals and objectives of the programs/service's Quality Improvement Plan,
- The quality improvement activities conducted during the past year, including the targeted process, systems, and outcomes;
- The performance indicators utilized,
- The findings of the measurement, data aggregation, assessment, and analysis processes, and
- The quality improvement initiatives taken in response to the findings.
- The progress towards meeting the Department's Annual Initiatives/Objectives.
    - For each of the objectives; a summary of progress including progress in relation to the objective(s).
    - A summary of the findings for each of the indicators used during the year. These summaries include both the outcomes of the measurement process and the conclusions and actions taken in response to these outcomes.
    - A summary of the progress toward the Quality Initiative(s)?
- Recommendations: Based upon the evaluation, the actions deemed necessary to improve the effectiveness of the Department's/program services.

## ANNUAL QI WORK PLAN EVALUATION FOR ALL PROGRAMS AND QI ACTIVITIES.

To be completed at the end of the fiscal year.

| Timeline: July 2023 – June 2024 | | | (*) = new goal |
|---|---|---|---|
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| *Goal: Assess access and utilization of services | | | |
| 1. Evaluate beneficiary access and utilization of MCDBHS to include:<br>a. Prepare beneficiary penetration and utilization rates by Hispanic/not Hispanic ethnicity and primary language in FY23.24. | Quarterly reports will show an improvement in penetration rate for Hispanics to a minimum of 2.40% by end of FY23.24. | Managed Care Designee<br>QI Systems Analyst | • EHR Insync Reports will be ran on a quarterly basis and presented at QIC.<br>• Data trending process will be completed. |

**Evaluation:**

**Goal for FY 24-25:**

BENEFICIARY/FAMILY SATISFACTION

Timeline: July 2023 – June 2024 (*) = new goal

| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
|---|---|---|---|
| *Goal: Conduct Semi-Annual Client Satisfaction Surveys | | | |
| 1. Conduct semi-annual beneficiary/client satisfaction surveys to measure client experience and satisfaction in FY23.24 to:<br>a. Establish baseline.<br>b. Identify and present solutions to barriers to treatment. | Establish baseline information after initial survey and compare to 2nd survey period to identify trends and areas of improvement. 1st survey to occur in November 2023 and 2nd survey to occur in March 2024 with findings report prepared by May 2024. | Managed Care Designee<br>Managed Care Analyst | • Conduct Initial Survey<br>• Compile Data<br>• Conduct Second Survey<br>• Compare both data findings to identify trends and areas of improvement |

**Evaluation:**

**Goal for FY 24-25:**

| Timeline: July 2023 – June 2024 | | | (*) = new goal |
|---|---|---|---|
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| *Goal: Conduct Peer Reviews for Quality | | | |
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| 1. Peer reviews will occur on a monthly basis beginning with soft launch in October 2023 and hard launch in January 2024.<br>a. Peer reviews will focus on quality and will follow a rotating schedule to ensure 3 charts per clinician are reviewed per FY. | 3 charts per FY per clinician will be reviewed during a peer review setting focusing on quality. Finding will be utilized to drive trainings and identify areas of needed improvement. | Managed Care Designee<br>QI Coordinator<br>Clinical Division Manager | • Establish review rotating schedule.<br>• Identify tool to be used for reviews<br>• Conduct review<br>• Gather data from review<br>• Present findings to leadership team |
| *Goal: Conduct Chart Reviews | | | |
| 2. Chart reviews will be completed on an annual basis in June 2024 as follows:<br>a. Review 5 adult and 5 youth charts | 5 adult charts and 5 youth charts will be audited for compliance with all aspects of treatment to include claims | Managed Care Designee<br>QI Coordinator | • Conduct review<br>• Gather data from review<br>• Present findings to leadership team |

**Evaluation:**

**Goal for FY 24-25:**

MONITOR SAFETY AND EFFECTIVENESS OF MEDICATION PRACTICES

| Timeline: July 2023 – June 2024 | | | (*) = new goal |
|---|---|---|---|
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| **Goal: Medication Monitoring Process in EHR** | | | |
| 1. Begin use of EHR Medication Monitoring form to produce data reports for monthly medication monitoring committee meeting and to ensure compliance and monitoring of the various requirements. | 100% of med monitoring forms will be completed within the EHR and placed in a folder with limited permissions in the document manager side of our EHR. | Managed Care Designee<br>QI Coordinator<br>Contracted Pharmacist | • Provide necessary training.<br>• Conduct reviews<br>• Pull data from EHR forms<br>• Present at Medication Monitoring Committee meetings |

**Evaluation:**

**Goal for FY 24-25:**

## CONTINUITY AND COORDINATION OF CARE WITH PHYSICAL HEALTH PROVIDERS

| Timeline: July 2023 – June 2024 | | | (*) = new goal |
|---|---|---|---|
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| *Goal: Collaborate with Managed Care Plans | | | |
| 1. Meet with CalViva managed care plan to coordinate and complete file transfers. | Complete data transfer by 01/01/2024 and establish data-sharing transaction log. | Managed Care Designee<br>Managed Care Analyst<br>MCPs | • Work with managed care plan partner to establish data exchanges via the established SFTP<br>• Create data-sharing transaction log |
| *Goal: Leverage SFTP data transfers to identify improvement initiatives | | | |
| 2. Begin the process of determine how to utilize transferred data for system improvement initiatives. | Utilization of MCP data for MHP improvement, undetermined at this time. | Managed Care Designee<br>Managed Care Analyst | • Identify data elements and determine how they may be utilized in the MHP for improvement of services |

**Evaluation:**

**Goal for FY 24-25:**

Timeline: July 2023 – June 2024 (*) = new goal

| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
|---|---|---|---|
| *Goal: Establish process early on in EHR transition to prevent gaps | | | |
| 1. With the planned implementation phase of the new EHR in January 2024, the following alerts will be established:<br>a. ICC/IHBS Screenings<br>b. Child and Family Team Meetings<br>c. 6-month SUD treatment justification<br>d. CANS/PSC-35<br>e. Annual Clinical Review | Alert system will produce timely completion of various clinical requirements | Managed Care Designee<br>Managed Care Analyst<br>Clinical Division Manager | • Work with new EHR vendor to understand workflows<br>• Leverage existing workflows or create new workflows to ensure timely completion of clinical components |
| *Goal: Establish clinical workflows | | | |
| 2. Ensure continued compliance with CalAIM clinical requirements during and after implementation of new EHR.<br>a. Determine need for new/revision of workflows<br>b. Train staff on new forms/processes | Clinical functions will continue and will be given special attention as transition to new EHR takes place. | Managed Care Designee<br>Managed Care Analyst | • Work with new EHR vendor to identify available workflows<br>• Determine how existing workflows can work within our system<br>• Begin producing training material as needed |
| *Goal: Provide ongoing training, support, and monitoring to support CalAIM implementation | | | |
| 3. CalAIM related policies will be communicated to staff as follows:<br>a. Onboarding training plan for new hires will include CalAIM related policies for review and completion attestation.<br>b. Additional training will be provided as need is identified or requests are received to maintain quality of services.<br>c. Policies and procedures will be reviewed annually. | Reports will be ran from Relias learning software showing policies have been reviewed. Additional trainings will be tracked and documented. | Managed Care Designee<br>Managed Care Analyst<br>Clinical Division Manager | • Establish an onboarding training plan which includes CalAIM policies for all new hires to complete and attest.<br>• Monitor quality and compliance with documentation standards and identify any gaps for which additional training may be needed.<br>• Provide on the spot clarification as needed and one-on-one training as requested.<br>• Assign review of policies on an annual basis to promote understanding and maintain documentation standards. |

**Evaluation:**

**Goal for FY 24-25:**

PERFORMANCE IMPROVEMENT PROJECTS (PIP) (WORK IN PROGRESS AND MAY CHANGE)

Timeline: July 2023 – June 2024 (*) = new goal

| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
|---|---|---|---|
| *Goal: Clinical PIP – Criss Mobile Unit Implementation | | | |
| 1. Establish a Madera County Department of Behavioral Health (MCDBH) Crisis Care Mobile Unit. | 1. Steady increased trend in dispatch of crisis mobile teams into the community from quarter to quarter (undetermined, new service)<br>2. Inpatient Admission stay log will show a decrease in admissions.<br>3. Contacts by crisis team at emergency room will decrease as per data collected. | Managed Care Designee<br>Managed Care Analyst<br>QI Coordinator<br>Crisis Division Manager | • Build infrastructure to include staffing, equipment, vehicles, materials, etc.<br>• Establish a process for dispatch and service data collection.<br>• Complete outreach activities to promote new service, create information material.<br>• Provide Crisis Services (contacts) out in the field within County boundaries at any time of the day or night. |
| *Goal: Non-Clinical PIP – Centralized Appointment Scheduling Process | | | |
| 2. Improve the process clients follow to schedule and/or reschedule, cancel or any other change to appointments in general. | 1. Number of scheduled ongoing individual therapy appointments (not post assessment) for already established clients within 30 days from prior individual therapy.<br>2. Number of post assessment plan development or individual therapy scheduled appointments within 30 days from date of initial assessment. | Managed Care Designee<br>Managed Care Analyst | • Gather statistics from EHR.<br>• Analyze data.<br>• Use the PIP tool to present results |

**Evaluation:**

**Goal for FY 24-25:**

| Timeline: July 2023 – June 2024 | | | (*) = new goal |
|---|---|---|---|
| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
| *Goal: Access to Services | | | |
| 1. Access Line Training will be provided to front desk staff as follows:<br>a. Upon hire, front desk staff will be trained on access line information to ensure they understand how to guide our clients<br>b. Staff will complete an access line refresher training bi-annually | A questionnaire component will be included in trainings to gather pre and post understanding of information provided. | QI Coordinator<br>Managed Care Designee<br>Front Desk Staff | • Develop training material<br>• Provide trainings as scheduled<br>• Gather pre-post findings<br>• Present to leadership team annually |

**Evaluation:**

**Goal for FY 24-25:**

COMPLIANCE WITH REQUIREMENT FOR CULTURAL COMPETENCE AND LINGUISTIC COMPETENCE

Timeline: July 2023 – June 2024 (*) = new goal

| Objective | Indicator/Measurement | Responsible Entity | Planned Steps/Intervention |
|---|---|---|---|
| | | | |
| *Goal: Develop Outreach Engagement | | | |
| 1. Develop successful outreach and engagement strategies to increase the penetration rate of Latinx/Hispanic client and find better methods of outreach to engage the Spanish speaking population. | Increase penetration rate by applying strategic outreach and engagement activities geared toward reaching the Latinx/Hispanic and monolingual population. | Cultural Competency Coordinator<br>Cultural Competence Designee<br>Compliance Manager | • Determine which strategies to apply to reach the desired population.<br>• Conduct outreach activities to engage said population.<br>• Monitor penetration rates to determine if approach is successful. |
| *Goal: Training Plan Development | | | |
| 2. Develop a training plan which aligns with Cultural Competence Plan goals in an effort to increase Latinx/Hispanic penetration rates. | Launch a survey to determine training interests and develop a training plan which incorporates necessary trainings to include cultural and linguistic aspects. | Cultural Competency Coordinator<br>Cultural Competence Designee<br>Compliance Manager | • Develop and launch training survey.<br>• Compile survey results.<br>• Draft training plan to include cultural and linguistic needs. |

**Evaluation:**

**Goal for FY 24-25:**